Funding Sources, Contracts, and Reports

Key Concepts and Topics

- Public health financing issues
- Revenue sources for local health jurisdictions
- Contracts that provide funding for key LHJ programs
- The Consolidated Contract between DOH and local health jurisdictions: components of the contract, contract processes, and key contacts
- The Budgeting, Accounting, and Reporting System (BARS)

Public Health Financing: Taking the Long View

"When the 1994 and 1996 Public Health Improvement Plans committed Washington State to a goal of "stable and sufficient" funding for public health, it was with the understanding that the current system wasn't working". *(Public Health Improvement Plan, 2002)* Four key problem areas of public health financing have been identified and studied by the Public Health Improvement Partnership (PHIP) Finance Committee:

1) Historical, persistent under funding
2) Erosion of core funding
3) Inconsistent levels of investment
4) Categorical constraints

According to the PHIP Finance Committee, "financing of public health today is the result of years of incremental decision-making, complex allocation methods, and a long history of categorical funding restrictions. This mix delivers inconsistent support across the public health system and causes some needs to go unmet." The committee calls for a system-wide approach to create the stable and sufficient funding needed for public health.

Current policy recommendations from the committee include

1) Increasing funding flexibility,
2) Maintaining accountability and
3) Linking funding to system performance.

More information about the work of the PHIP Finance Committee is available online at http://www.doh.wa.gov/PHIP/Financing/default.htm. The following paragraphs describe the current mix of funding for local health jurisdictions (LHJs) and the major contracts through which most LHJs receive that funding.

Revenue Sources for Local Public Health

Each county is financially responsible for the cost of public health activities in its respective jurisdiction. The local Board of Health for each LHJ sets the agency's annual budget and determines the portion of financial responsibility of each local government within the jurisdiction. However, the local government contribution is only one of many sources of revenue for LHJs.

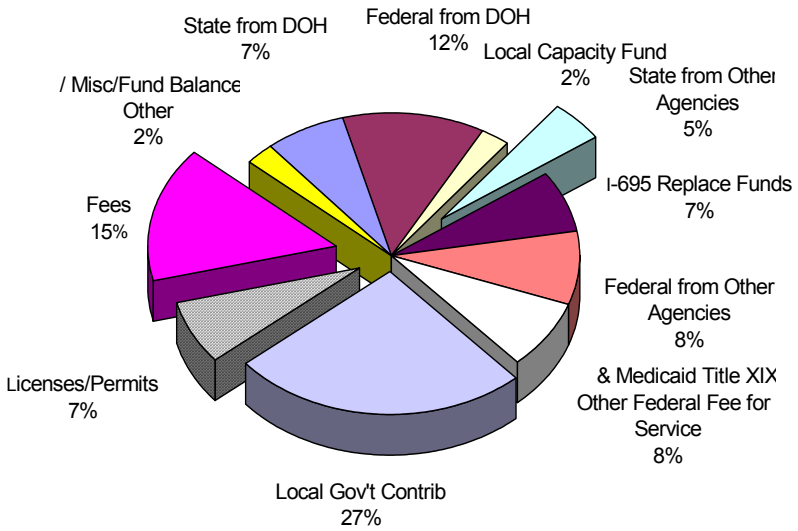
Most LHJ budgets currently reflect a complex mix of funding sources coming from different entities, agencies and programs at local, state, and federal levels. While some of these funds are dedicated to public health, this category represents a relatively small proportion of total funding for LHJs. Earned income is, in most cases, a larger revenue category. This category has played an increasing role on the revenue side of LHJ budgets in recent years. Earned income comes from a variety of sources, such as:

- Contracts for services with state agencies (Department of Health, Department of Ecology, Department of Social and Health Services).
- Contracts with local agencies such as school districts or Head Start
- Contracts with other departments within local government, for services such as health services within jails and juvenile detention facilities
- Medicaid, Medicare, private pay and private insurance reimbursement for clinical services
- Administrative matching funds from Medicaid for specific services for Medicaid-eligible clients
- Environmental health permits and licenses, and
- Vital records fees.

Increasingly, LHJs are applying for federal and privately funded grants to fund needed services. Each of these different fund sources usually comes with its own set of billing and reporting requirements, which often increase the administrative burden on the LHJs. This reliance on "earned income" also means that many LHJs must allocate their resources to programs and services that may or may not align with community health priorities, core public health functions and essential public health services.

The chart below illustrates the proportion of LHJ funding (statewide) from various categories in 2003.

Local Health Jurisdiction Funding Sources, 2003



Source: 2003 BARS Revenue Summary
http://www.doh.wa.gov/msd/OFS/2003rs/Revsum.htm

Local Revenue

LHJs have essentially two local revenue sources to support public health functions: general fund (general tax sources) and licenses, permits and fees. In 2003, the combined totals of these two sources of local funds represented 49% of LHJ revenue statewide. However, the proportion of local revenue for each LHJ varies greatly across the state.

General Tax Sources
At one time, local tax dollars were, by far, the single largest revenue category in local public health budgets. Over the years, increasing local demands for criminal justice and other needs, together with the growth of federal and state public health and social service program funding opportunities and other factors, have reduced the proportion of locally raised tax revenue in local public health agency budgets. In 2003, local government contributions provided 27% of all LHJ revenue statewide.

The proportion of local government funding for public health, as well as the amount of local tax dollars spent on public health on a per capita basis varies greatly across the state. In 2001, county tax support for local public health ranged from 94 cents to $26.05 per person per year. The 2002 Public Health Improvement Plan Report identified these inconsistent levels of local investment in public health as one of the key issues in public health financing. The report notes that there is no minimum level of investment for public health, creating the potential for great disparities over time. Many factors determine the amount invested locally: overall county revenues, past levels of spending, decisions about fees, and participation by cities within a county.

Licenses, Permits and Fees
The legislature, through RCW 70.05.060 (7), granted authority to local Boards of Health to set fees for services, provided the fees do not exceed the cost of providing the service. In 1976, the Washington Legislature repealed dedication of a 21-cent local property tax to public health, but did not replace the funds lost with another dedicated revenue source. As a result, most LHJs began to rely more heavily on revenue from fees. Many LHJs began to substantially increase fees to make up for the lost revenue. In 2003, revenue from licenses, permits and fees represented 22% of total LHJ revenue.

- Land use (on-site sewage and review of subdivisions), food establishment, temporary food service, swimming pools/spas, camps and camping vehicle parks, and permits and licenses for installers/designers of on-site sewage systems make up the bulk of fees charged for environmental health services.
- Many LHJs collect fees for clinical services, classes, and other health services. Some federal fund sources require sliding fee schedules based on the individual's or family's income (if fees are charged for services that are partially funded by these federal sources). There may also be requirements that no one be denied services based on inability to pay.
- LHJs also charge fees for issuing birth and death certificates, performing laboratory tests, and other services.

There is wide variation in local fees in terms of fee level, market area to support fees, local philosophy underlying cost recovery, and whether any fees will be charged for certain services.

State Funding of Local Public Health

In 2003, state funds from all sources represented 21% of LJH revenue statewide. State funds in LHJ budgets come from a variety of sources. Much of this funding is attached to specific programs, but two sources of state funding" are "flexible", and can be used at the local agency's discretion to meet local public health needs (Local Capacity Development Funds and other state funds identified to support local public health)

Local Capacity Development Funds
Local Capacity Development Funding (LCDF) is funding provided biennially by the Washington State Legislature to be used by local health jurisdictions to address public health issues, concerns or priorities in their respective jurisdiction. The genesis of this funding was the Health Services Act of 1993, through which the Legislature appropriated $10 million to be distributed to local health jurisdictions throughout Washington State. That appropriation was termed "Urgent Needs" and represented a new approach to providing state funds for public health. The funding was not tied to specific categories of services, but rather was to provide local health jurisdictions with the flexibility to spend funds in a way they felt would best address issues, problems or priorities specific to their jurisdiction. These funds are distributed, generally speaking, on a per capita basis, with the stipulation that no jurisdiction receives less than a threshold that was established in 1995. The funds (over 8 million dollars in 2003) are distributed to LHJs via the DOH Consolidated Contract.

Other State Support for Local Public Health
A secondary provision of the Health Services Act of 1993 was the Legislature's decision to remove cities from ongoing funding of local public health. The Legislature accomplished this action by assigning 3.4% of the cities Motor Vehicle Excise Tax (MVET) to local health jurisdictions. The MVET, the annual motor vehicle licensing fee, was based on a percentage of the vehicle's value. It was anticipated MVET dollars would increase as the value of vehicles increased.

Initiative 695 and I-695 replacement funds (MVET "backfill")
The voters of Washington State voted in 1999 to pass an initiative (I-695) to reduce the motor vehicle excise tax to a flat $30. This action immediately affected the amount of funds available to local public health from MVET. A provision of I-695 mandated government officials to put all fee increases to a vote of the public. The intent of I-695 was to reduce the MVET and not allow local and state government to compensate for the MVET loss by charging additional fees. I-695 was challenged in court and found to be unconstitutional, but was implemented by the Legislature anyway, resulting in loss of funds dedicated to local public health.

The 2000 Legislature acted to replace a portion of the funds lost to public health through I-695. The Legislature allocated money from the state's "Rainy Day Account" to replace 90% of the dollars that public health would have received from MVET. This has continued through the 2005 fiscal year. This state revenue source has been one of the largest single contributions to local public health financing, and is dependent upon reauthorization by the legislature every biennium. In 2003, 23 million dollars from this source were allocated to LHJs representing 7% of total LHJ

revenue statewide. The DOH consolidated contract with LHJs is the vehicle for distributing these funds to LHJs.

State Funding for Specific Programs and Services
LHJs also receive state funds through contracts with various state agencies. Most of this funding is considered categorical, which means that its use is specified for a specific program or service. Funds received for HIV/AIDS prevention and education, and Tobacco Prevention are some examples. For most DOH programs, the amount of funds going to a specific LHJ is determined by a funding formula that considers population and other factors. State funds are also disbursed to LHJs through fee for service arrangements for some specific services.

Federal Revenue

Federal funds are received by LHJs through grants, contracts, and fees for services. In 2003, federal funds from all sources represented 28% of LHJ revenue statewide, 20% flowing through DOH and other state agencies, and 8% from federal fee for service reimbursement.

Federal Funds in Contracts
In most cases, the federal funds don't pass directly from the federal level to local agencies. Rather, most federal funds are "passed-through" state agencies, which contract with the local agencies for specific program services and activities and specify the federal requirements for the funds through contract language. Some of these contracts are described in the "Contracts" section below. Information about requirements associated with federal funding in contracts is in the "Management and Administration" section of this Orientation.

Federal "Fee-for-Service" Revenue
LHJs may apply to be a Medicare Part B provider to obtain reimbursement for influenza and pneumococcal vaccines given to Medicare beneficiaries. They may also apply to become providers for the state Medicaid program. LHJs should develop a pricing structure and sliding fee scale for services that are billed to Medicaid and Medicare. Other fee for service revenue from federal sources comes through programs such as Maternity Support Services and Infant Case Management (previously called "First Steps".

Medicaid Administrative Match
Medicaid Administrative Match is a significant revenue source for some LHJs, particularly in funding some services (e.g. outreach and linkage) to the MCH population, and some STD and TB control services. Based on documented time studies, LHJs are reimbursed by Medicaid for some of the LHJ resources spent on certain activities on behalf of Medicaid-eligible clients. The rate of reimbursement varies depending on the type of service and, in some cases, the type of provider.

Contracts

Most LHJs contract with other entities, including state agencies, local governments, or non-profit agencies, to provide specific services. In the case of contracts from state agencies, the contract frequently combines state and federal funding. The combination may simply expand the program's funding. Or, the federal program may require non-federal "matching"

funds to be used in order to expend the federal amounts, and the state funds are used to provide this match. The combination of sources often adds complexity to record-keeping since the contract period, the federal fiscal year for use of the funds, the state fiscal year for use of the state funds, and the LHJ fiscal year will seldom be the same.

Contracts with State Agencies

Department of Social and Health Services (DSHS)
Contracts with DSHS have become an important source of funding for LHJs. For instance, DSHS contracts with some LHJs for services provided through the Foster Care Passport program, for the Alternative Response System, Infant Toddler Early Intervention Program, and for the WorkFirst program. These programs and services are described in the "Local Health Jurisdictions" section of the Orientation.

Department of Ecology (Ecology)
Ecology is a significant external funding source for environmental health programs in LHJs. Ecology provides funding in a number of Solid Waste activities as well as water program activities.

Department of Health

Consolidated Contract
The Department of Health (DOH) contracts with all LHJs through a "consolidated contract" that combines statements of work, reporting requirements, and other contract provisions for various programs contracting with LHJs. The Consolidated Contract (ConCon) was developed in the early 1980's in order to simplify and centralize the process of contracting between DOH and LHJs for multiple program services. This approach provides a more integrated and consistent process for planning, allocating resources, managing, and monitoring contract activities. Currently, the two-year contract passes over $100 million in federal and state funds to LHJs for a wide range of activities, including Emergency Preparedness and Response, Shellfish, Drinking Water, HIV/AIDS, WIC, Tobacco, Maternal and Child Health Services, STD, Immunizations and others. Federal requirements and restrictions on the use of the funds are identified within the contract.

DOH program staff members work with LHJs to determine the contract statement of work and "deliverables" for each program. Funds are allocated to LHJs based on various program funding formulas and fee-for-service determinations. Funding to the LHJ is identified in the contracts on a single "allocation sheet", which lists, by fund source code, the funds allocated for the specific time periods required by the fund sources. LHJs submit monthly billings for expenditures, up to the allocated amount for each fund source within the specified time period. Billings for each fund source are combined on a single A-19 voucher.

DOH program staff are required to conduct a six-month and twelve-month monitoring review of program deliverables with each LHJ in order to assure and document that contract requirements are being met. Some programs require more frequent monitoring. Any funding and program changes are reflected in contract amendments, which are completed roughly six times a year by the DOH contracts office.

Each LHJ has an individual designated as the local ConCon Coordinator. These individuals help coordinate contract-related business communication between DOH and LHJs. Current lists of local ConCon Coordinators and DOH Program Staff are available on the ConCon website at (http://www.doh.wa.gov/concon/ContactListsTitlePage/ContactListsTitlePage.htm).

Key contacts

Staff from the DOH Division of Financial Services (Office of Contract, Properties and Procurements (OCPP)) and the Division of Community and Family Health, Office of the Assistant Secretary (CFH-OAS) coordinate and manage the consolidated contract processes. Key contacts for information and technical assistance on the Consolidated Contract are listed below:

Issue	Contact
Contract monitoring, ConCon website, East/West meetings, and cross-program coordination	Claudia Lewis, Program Manager CFH-OAS (360) 236-3726 Claudia.Lewis@doh.wa.gov
Contract coordination, processing, and signature contact	Betty Brickl, Contract Specialist Office of Contracts, Properties, & Procurement (360) 236-3924 Betty.Brickl@doh.wa.gov
A-19s processing and payment	Linda Hildebrand, Analyst Grants Management (360) 236-3941 Linda.Hildebrand@doh.wa.gov
BARS reports, coding, cost allocation, and accounting practice	Steve Russman, Financial Coordinator Division of Financial Services (360) 236-3941 Steve.Russman@doh.wa.gov
Specific program content, reporting requirements, and allocations	DOH Program Staff http://www.doh.wa.gov/concon/ContactListsTitlePage/ContactListsTitlePage.htm

Online access

Copies of the contract, including forms, reporting requirements and current amendments for each LHJ are maintained online and available to download at the Consolidated Contracts Web page at http://www.doh.wa.gov/concon/portal.htm

Budgeting, Accounting, and Reporting System

RCW 43.09.200 gives the State Auditor authority to prescribe the use of a uniform chart of accounts and procedures for local government. The Budgeting Accounting and Reporting System (BARS) is the system prescribed. Within this uniform chart of accounts, all public health expenditures are recorded under the same expenditure category (562.00) Local health jurisdictions must use the BARS, and are required through the DOH consolidated contract to report annual expenditures and revenues to DOH within a prescribed format that uses BARS expenditure and revenue coding and processes.

The *BARS Supplemental Handbook for Public Health*

The BARS Supplemental Handbook for Public Health is intended to provide guidelines to ensure uniform reporting on revenues according to sources and expenditures by type of broad service categories for public health activities. These service categories are generally referred to as "programs". The most recent version of the " BARS Supplemental Handbook for Public Health" is available online through the DOH publications list at http://www.doh.wa.gov/Publicat/publications.htm

BARS Summary Reports: Funding of Local Health Jurisdictions

The Department of Health is the central point to gather information for public health related programs. DOH works to consolidate information from all LHJs to prepare reports that will reflect statewide LHJ program expenditures and revenues by fund source. BARS data do not show the full universe of investment in local public health departments since the reports do not capture public health expenditures outside of LHJs, and in some cases, environmental health services may not be part of the local public health agency.

The most recent two years of BARS summary report data are maintained online and available through the DOH publications page under the title "Revenue Summary Funding of Local Health Jurisdictions" (http://www.doh.wa.gov/Publicat/publications.htm). This report provides useful information about expenditures and revenue sources for LHJs on both a statewide and individual agency basis. Various analyses can be performed from these reports, such as comparing the proportion and source of fee or Medicaid revenue for a program across agencies of similar size; comparing total program costs etc. In addition to summaries by BARS "program" code, summaries of expenditures and revenues have been created that align with the Standards for Public Health in Washington State.